Appendix 10
Prior Authorization Request Form
Spell of Illness Sample (Occupational Therapy)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 115

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567892
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, ImA.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow St. Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YY
6 SEX: M ☐ F ☒
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX)XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I. M. Provider, 1 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO.: 10000000
10 DX: PRIMARY: 854T.B.I.
11 DX: SECONDARY: 814.0 (R) Wrist fx.
12 START DATE OF SOI: MM/DD/YY
13 FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
Q0109	0T	8	9	Evaluation	01	
97535	0T	8	9	Act of daily living (each 15 min.)	34	
97770	0T	8	9	Cognitive - memory (each 15 min.)	34	
97110	0T	8	9	Range of motion (each 15 minutes)	34	
97265	0T	8	9	Joint mob. periph. (initial 15 min.)	12	
97250	0T	8	9	Myofas. Rel/Soft tissue (each 15 min.)	34	
*Each session will include 30 min. ADL and combination of other procedures to *equal* one hour of treatment					TOTAL CHARGE	21

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)
24 *I.M. Provider* Begin SOI MM/DD/YY (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
☐ APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED
☐ MODIFIED — REASON:
☐ DENIED — REASON:
☐ RETURN — REASON:

DO NOT write in this space.
Reserved for Medicaid use.

DATE — CONSULTANT/ANALYST SIGNATURE

482-120